Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief Complaint (Why are you seeing the doctor?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Part 1. Symptoms

**Eyes and Ears**

|  |  |  |
| --- | --- | --- |
| Itchy & Watery Eyes | Swelling around Eyes | Ear Infections |
| Red Eyes | Light Hurts Eyes | Decreased Hearing |

**Nose and Sinuses**

|  |  |  |
| --- | --- | --- |
| Stuffy | Decreased Smell | Post Nasal Drainage |
| Runny | Frequent Colds | Mouth Breathing |
| Itchy | Nosebleeds | Nose Spray Use |
| Sneezing | Nasal Polyps | Sinus Headaches |

**Throat and Lungs**

|  |  |  |
| --- | --- | --- |
| Sore Throat | Wheezing | Lung Infections |
| Throat Infections | Coughing |  |
| Tonsillitis | Shortness of Breath |  |

**Skin**

|  |  |
| --- | --- |
| Hives | Eczema |

Symptoms have been worse for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Part 2. Variation of Symptoms.

**Do your symptoms occur:**

Daily 3-4x a week 1-2x a week less than 1x weekly

**Do you have trouble sleeping at night due to symptoms?**  Yes No

**On the weekends, are your symptoms:**  Better Worse No Difference

**Are your symptoms worse during specific times of the day?**

Morning Evening Bedtime No Difference

**Are your symptoms worse during any season?**

Spring Summer Fall Winter

**Check which month(s) in which nasal symptoms occur:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Jan. | Feb. | Mar. | April. | May. | Jun. |
| Jul. | Aug. | Sept. | Oct. | Nov. | Dec |

**Check which month(s) in which eye symptoms occur:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Jan. | Feb. | Mar. | April. | May. | Jun. |
| Jul. | Aug. | Sept. | Oct. | Nov. | Dec |

**Check which month(s) in which throat and lung symptoms occur:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Jan. | Feb. | Mar. | April. | May. | Jun. |
| Jul. | Aug. | Sept. | Oct. | Nov. | Dec |

## Part 3. Precipitation Factors.

**Which of these make your symptoms worse? Please Circle.**

Sweeping or dusting Dogs Dampness/Humidity

Vacuuming Horses Temperature Changes

Making the Bed Other Animals Heat

Shaking Rugs Birds Cold Air

Contact with Old Furniture Feather Pillows Drafts/Wind

Basement Cigarette Smoke Exertion

Mowing Grass Perfumes/Deodorant Laughing/Coughing

Hay or Straw Insect Spray Respiratory Infections

Raking Leaves Paint Colds

Cottages or Cabins Hair Spray Emotional Upsets

Moldy or Musty Areas Enzyme Detergents Menses

Cats Air Pollution Fatigue

## Part 4. Previous Allergy Evaluation and Treatment.

**Please check what applies to you.**

**Have you had allergy skin tests or blood tests?** Yes No

**Did the results of these tests indicate that you were allergic to:**

Pollen Dust Dust Mites Pets Mold Others

**Have you received allergy shots or immunotherapy?**  Yes No

**If yes, when did you receive these shots or treatments?**

From age\_\_\_\_\_\_\_ until age \_\_\_\_\_\_\_.

**Was there any improvement in your symptoms after receiving injections?** Yes No

**Did you have any bad reactions to allergy injections?** Yes No

If yes, then please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Part 5. Past Medical History

**Medication List**

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dose** | **Times per Day** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Allergy and Asthma Medications used in the past**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please check what applies to you and explain what applies to you.**

**Have you had any allergic reactions or any type of bad reactions to any medications?**

Yes No

If yes, which medications caused these reactions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do any foods or beverages bother you? (cause cramps, rash, swelling, itching, make other symptoms worse, etc.)**

Yes No

If yes, which foods or beverages cause these reactions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had a bad reaction to a bee, wasp, or yellow jacket sting?**

Yes No

If yes, then please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Other Medical Illnesses**

Please list any medical illnesses or conditions that are not included in the previous sections.

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**Surgeries**

Please list any surgeries you have had.

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**Hospitalizations**

Please list the reason for any hospitalizations you have had and their approximate date.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Part 6. Family History

Please check what applies to each family member.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Asthma** | **Hay Fever** | **Eczema** | **Hives** | **Sinus** |
| **Mother** |  |  |  |  |  |
| **Father** |  |  |  |  |  |
| **Brother** |  |  |  |  |  |
| **Sister** |  |  |  |  |  |
| **Children** |  |  |  |  |  |
| **Aunt** |  |  |  |  |  |
| **Uncle** |  |  |  |  |  |
| **Grand Mother** |  |  |  |  |  |
| **Grand Father** |  |  |  |  |  |

## Part 7. Social History

**Please check what applies to you, and fill in the blanks where needed.**

**What is your line of work?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever worked around:**

|  |  |  |
| --- | --- | --- |
| Rubber or Latex | Asbestos | Moldy Hay or Grain |
| Pigeons or  Parakeets | Plastics/Acrylics | Steel Mill |
| Beryllium | Sand Blasting | Welding Arc |
| Detergent Factory | Meat Wrappers | Sugar Cane Fields |
| A Mine or Quarry |  |  |

**Are your symptoms worse at work?** Yes No

**Marital Status:** Married Single Divorced

**Do you now, or did you ever smoke?**  Yes No

If yes, how much and what did you smoke per day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many years did you smoke?** \_\_\_\_\_\_\_\_\_

**Are you exposed to second hand smoke?** Yes No

If yes, where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How much alcohol do you drink?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your recreational drug use?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Part 8. Environmental History

**Residence Type**

|  |  |  |
| --- | --- | --- |
| House | Apartment | Other |

**Hold old is your present home?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**In what area is your home located?**

|  |  |  |
| --- | --- | --- |
| Urban | Suburban | Rural |
| Heavily Wooded | Industrial |  |

**Heating System**

|  |  |  |
| --- | --- | --- |
| Forced Air | Steam | Hot Water |
| Space Heater | Electric  Radiant Coils | None |

**Air Conditioning**

|  |  |  |
| --- | --- | --- |
| None | Central | Room |

**Humidifier**

|  |  |  |
| --- | --- | --- |
| None | Central | Room |

**Does you home have a basement?** Yes No

**If yes, is it musty smelling?** Yes No

**How many beds are in your bedroom?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mattress Type**

|  |  |  |  |
| --- | --- | --- | --- |
| Inner Spring | Cotton Felt | Feather | Foam |

**Pillow Type**

|  |  |  |  |
| --- | --- | --- | --- |
| Foam | Dacron | Cotton | Feather |

**Do you have any of the following in your bedroom?**

|  |  |  |
| --- | --- | --- |
| Bookcase | Stuffed Toys | Upholstered  Furniture |
| Pets | House Plants |  |

**Bedroom Flooring Type**

|  |  |  |
| --- | --- | --- |
| Wall to Wall  Carpeting | Hardwood | Linoleum/Vinyl |

## Part 9. For Women of Childbearing Age

**What is your birth control method?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you Pregnant?** Yes No

**You plan a pregnancy in** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ years

## Part 10. Review of Systems

**Please check any symptoms or problems you have.**

**Constitutional Symptoms**

|  |  |  |  |
| --- | --- | --- | --- |
| Fatigue | Poor Appetite | Weakness | Weight Loss |
| Weight Gain | Fever | Chills | Night Sweats |

**Eyes**

|  |  |  |  |
| --- | --- | --- | --- |
| Cataracts | Blurry Vision | Glaucoma | Eye Pain |

**Ears, Nose, Mouth, and Throat**

|  |  |  |  |
| --- | --- | --- | --- |
| Ear-Aches | Ringing in Ears | Broken Nose | Hoarseness |
| Decreased  Hearing | Soreness in  Mouth | Neck Pain |  |

**Pulmonary**

|  |  |  |  |
| --- | --- | --- | --- |
| Pneumonia | Bronchitis | Coughing  Blood | Tuberculosis |

Date of last chest x-ray \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cardiovascular**

|  |  |  |
| --- | --- | --- |
| Chest Pain | Heart Murmur | Irregular Rhythm |
| Swelling of Legs | Palpitations | Blood Clots |
| High Blood Pressure | Easy Bruising | Heart Failure |

**Gastrointestinal**

|  |  |  |
| --- | --- | --- |
| Heartburn | Acid Regurgitation | Choking |
| Difficulty Swallowing | Reflux | Hiatal Hernia |
| Ulcer | Diarrhea | Liver Disease |
| Nausea/Vomiting |  |  |

**Genitourinary**

|  |  |  |
| --- | --- | --- |
| Bladder Infections | Urinal Tract Infections | Kidney Trouble |
| Yeast Infections | Menstrual  Abnormalities |  |

**Endocrine**

|  |  |  |
| --- | --- | --- |
| Diabetes | Thyroid Disease | Heat Intolerance |

**Musculoskeletal**

|  |  |  |
| --- | --- | --- |
| Joint Pain | Muscle Pain | Back Pain |
| Arthritis/Gout | Osteoporosis |  |

**Skin and/or Breast**

|  |  |  |
| --- | --- | --- |
| Rashes | Swelling | Infections |
| Athlete’s Foot | Varicose Veins |  |

**Neurological**

|  |  |  |
| --- | --- | --- |
| Headaches | Dizziness | Vertigo |
| Numbness | Seizures | Weakness of Limbs |

**Psychiatric**

|  |  |  |
| --- | --- | --- |
| Depression | Anxiety | Mood Swings |
| Trouble Sleeping | Stress |  |

**Allergic/Immunologic**

|  |  |  |
| --- | --- | --- |
| Hay Fever | Asthma | Sinus Infections |
| Food Allergies | Frequent Infections |  |

Please have your primary care doctor fax or send recent blood tests and x-ray results to our office.

Add any additional comments you would like to make regarding your problem.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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